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Author(s): August B. Hollingshead and Frederick C. Redlich
Source: *American Sociological Review*, Vol. 18, No. 2 (Apr., 1953), pp. 163-169
Published by: American Sociological Association
Stable URL: http://www.jstor.org/stable/2087725
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SOCIAL STRATIFICATION AND PSYCHIATRIC DISORDERS

AUGUST B. HOLLINGSHEAD AND FREDERICK C. REDLICH*

Yale University

THE research reported here grew out of the work of a number of men, who, during the last half century, have demonstrated that the social environment in which individuals live is connected in some way, as yet not fully explained, to the development of mental illness.[1] Medical men have approached this problem largely from the viewpoint of epidemiology.[2] Sociologists, on the other hand, have analyzed the question in terms of ecology,[3] and of social disorganization.[4] Neither psychiatrists nor sociologists have carried on extensive research into the specific question we are concerned with, namely, interrelations between the class structure and the development of mental illness. However, a few sociologists and psychiatrists have written speculative and research papers in this area.[5]

* Paper read at the annual meeting of the American Sociological Society, September 3–5, 1952. The research reported here is supported by a grant from the National Institute of Mental Health of the United States Public Health Service to Yale University under the direction of Dr. F. C. Redlich, Chairman, Department of Psychiatry, and Professor August B. Hollingshead, Department of Sociology.

[1] For example, see, A. J. Rosanoff, *Report of a Survey of Mental Disorders in Nassau County, New York,* New York: National Committee for Mental Hygiene, 1916; Ludwig Stern, *Kulturkreis und Form der Geistigen Erkrankung,* (Sammlung Zwanglosen Abshandlungen aus dem Gebiete der Nerven-und-Geiteskrankheiten), X, No. 2, Halle a. S:C. Marhold, 1913, pp. 1–62; J. F. Sutherland, "Geographical Distribution of Lunacy in Scotland," *British Association for Advancement of Science,* Glasgow, Sept. 1901; William A. White, "Geographical Distribution of Insanity in the United States," *Journal of Nervous and Mental Disease,* XXX (1903), pp. 257–279.

[2] For example, see: Trygve Braatoy, "Is it Probable that the Sociological Situation is a Factor in Schizophrenia?" *Psychiatrica et Neurologica,* XII (1937), pp. 109–138; Donald L. Gerard and Joseph Siegel, "The Family Background of Schizophrenia," *The Psychiatric Quarterly,* 24 (January, 1950), pp. 47–73; Robert W. Hyde and Lowell V. Kingsley, "Studies in Medical Sociology, I: The Relation of Mental Disorders to the Community Socio-economic Level," *The New England Journal of Medicine,* 231, No. 16 (October 19, 1944), pp. 543–548; Robert W. Hyde and Lowell V. Kingsley, "Studies in Medical Sociology, II: The Relation of Mental Disorders to Population Density," *The New England Journal of Medicine,* 231, No. 17 (October 26, 1944), pp. 571–577; Robert M. Hyde and Roderick M. Chisholm, "Studies in Medical Sociology, III: The Relation of Mental Disorders to Race and Nationality," *The New England Journal of Medicine,* 231, No. 18 (November 2, 1944), pp. 612–618; William Malamud and Irene Malamud, "A Socio-Psychiatric Investigation of Schizophrenia Occurring in the Armed Forces," *Psychosomatic Medicine,* 5 (October, 1943) pp. 364–375; B. Malzberg, *Social and Biological Aspects of Mental Disease,* Utica, N. Y.: State Hospital Press, 1940; William F. Roth and Frank H. Luton, "The Mental Health Program in Tennessee: Statistical Report of a Psychiatric Survey in a Rural County," *American Journal of Psychiatry,* 99 (March, 1943), pp. 662–675; J. Ruesch and Others, *Chronic Disease and Psychological Invalidism,* New York: American Society for Research in Psychosomatic Problems, 1946; J. Ruesch and others, *Duodenal Ulcer: A Socio-psychological Study of Naval Enlisted Personnel and Civilians,* Berkeley and Los Angeles: University of California Press, 1948; Jurgen Ruesch, Annemarie Jacobson, and Martin B. Loeb, "Acculturation and Illness," *Psychological Monographs: General and Applied,* Vol. 62, No. 5, Whole No. 292, 1948 (American Psychological Association, 1515 Massachusetts Ave., N.W., Washington 5, D. C.); C. Tietze, Paul Lemkau and M. Cooper, "A Survey of Statistical Studies on the Prevalence and Incidence of Mental Disorders in Sample Populations," *Public Health Reports,* 1909–27, 58 (December 31, 1943); C. Tietze, P. Lemkau and Marcia Cooper, "Schizophrenia, Manic Depressive Psychosis and Social-Economic Status," *American Journal of Sociology,* XLVII (September, 1941), pp. 167–175.

[3] Robert E. L. Faris, and H. Warren Dunham, *Mental Disorders in Urban Areas,* Chicago: University of Chicago Press, 1939; H. Warren Dunham, "Current Status of Ecological Research in Mental Disorder," *Social Forces,* 25 (March, 1947), pp. 321–326; R. H. Felix and R. V. Bowers, "Mental Hygiene and Socio-Environmental Factors," *The Milbank Memorial Fund Quarterly,* XXVI (April, 1948), pp. 125–147; H. W. Green, *Persons Admitted to the Cleveland State Hospital,* 1928–1937, Cleveland Health Council, 1939.

[4] R. E. L. Faris, "Cultural Isolation and the Schizophrenic Personality," *American Journal of Sociology,* XXXIX (September, 1934), pp. 155–169; R. E. L. Faris, "Reflections of Social Disorganization in the Behavior of a Schizophrenic Patient," *American Journal of Sociology,* L (September, 1944), pp. 134–141.

[5] For example, see: Robert E. Clark, "Psychoses, Income, and Occupational Prestige," *American Journal of Sociology,* 44 (March, 1949), pp. 433–440;

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The present research, therefore, was designed to discover whether a relationship does or does not exist between the class system of our society and mental illnesses. Five general hypotheses were formulated in our research plan to test some dimension of an assumed relationship between the two. These hypotheses were stated positively; they could just as easily have been expressed either negatively or conditionally. They were phrased as follows:

I. The *expectancy* of a psychiatric disorder is related significantly to an individual's position in the class structure of his society.

II. The *types* of psychiatric disorders are connected significantly to the class structure.

III. The type of *psychiatric treatment* administered is associated with patient's positions in the class structure.

IV. The *psycho-dynamics* of psychiatric disorders are correlative to an individual's position in the class structure.

V. *Mobility* in the class structure is neurotogenic.

Each hypothesis is linked to the others, and all are subsumed under the theoretical assumption of a functional relationship between stratification in society and the prevalence of particular types of mental disorders among given social classes or strata in a specified population. Although our research was planned around these hypotheses, we have been forced by the nature of the problem of mental illness to study *diagnosed* prevalence of psychiatric disorders, rather than *true* or *total* prevalence.

Robert E. Clark, "The Relationship of Schizophrenia to Occupational Income and Occupational Prestige," *American Sociological Review,* 13 (June, 1948), pp. 325–330; Kingsley Davis, "Mental Hygiene and the Class Structure," *Psychiatry,* I (February, 1938), pp. 55–56; Talcott Parsons, "Psychoanalysis and the Social Structure," *The Psychoanalytical Quarterly,* XIX, No. 3 (1950), pp. 371–384; John Dollard and Neal Miller, *Personality and Psychotherapy,* New York: McGraw-Hill, 1950; Jurgen Ruesch, "Social Technique, Social Status, and Social Change in Illness," Clyde Kluckhohn and Henry A. Murray (editors), in *Personality in Nature, Society, and Culture,* New York: Alfred A. Knopf, 1949, pp. 117–130; W. L. Warner, "The Society, the Individual and his Mental Disorders," *American Journal of Psychiatry,* 94, No. 2 (September, 1937), pp. 275–284.

METHODOLOGICAL PROCEDURE

The research is being done by a team of four psychiatrists,[6] two sociologists,[7] and a clinical psychologist.[8] The data are being assembled in the New Haven urban community, which consists of the city of New Haven and surrounding towns of East Haven, North Haven, West Haven, and Hamden. This community had a population of some 250,000 persons in 1950.[9] The New Haven community was selected because the community's structure has been studied intensively by sociologists over a long period. In addition, it is served by a private psychiatric hospital, three psychiatric clinics, and 27 practicing psychiatrists, as well as the state and Veterans Administration facilities.

Four basic technical operations had to be completed before the hypotheses could be tested. These were: the delineation of the class structure of the community, selection of a cross-sectional control of the community's population, the determination of who was receiving psychiatric care, and the stratification of both the control sample and the psychiatric patients.

August B. Hollingshead and Jerome K. Myers took over the task of delineating the class system. Fortunately, Maurice R. Davie and his students had studied the social structure of the New Haven community in great detail over a long time span.[10] Thus, we had a large body of data we could draw upon to

[6] F. C. Redlich, B. H. Roberts, L. Z. Freedman, and Leslie Schaffer.

[7] August B. Hollingshead and J. K. Myers.

[8] Harvey A. Robinson.

[9] The population of each component was as follows: New Haven, 164,443; East Haven, 12,212; North Haven, 9,444; West Haven, 32,010; Hamden, 29,715; and Woodbridge, 2,822.

[10] Maurice R. Davie, "The Pattern of Urban Growth," G. P. Murdock (editor), in *Studies in the Science of Society,* New Haven: 1937, pp. 133–162; Ruby J. R. Kennedy, "Single or Triple Melting-Pot: Intermarriage Trends in New Haven, 1870–1940," *American Journal of Sociology,* 39 (January, 1944), pp. 331–339; John W. McConnell, *The Influence of Occupation Upon Social Stratification,* Unpublished Ph.D. thesis, Sterling Memorial Library, Yale University, 1937; Jerome K. Myers, "Assimilation to the Ecological and Social Systems of a Community," *American Sociological Review,* 15 (June, 1950), pp. 367–372; Mhyra Minnis, "The Relationship of Women's Organizations to the Social Structure of a City," Unpublished Ph.D. Thesis, Sterling Memorial Library, Yale University, 1951.

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aid us in blocking out the community's social structure.

The community's social structure is differentiated *vertically* along racial, ethnic, and religious lines; each of these vertical cleavages, in turn, is differentiated *horizontally* by a series of strata or classes. Around the socio-biological axis of race two social worlds have evolved: A Negro world and a white world. The white world is divided by ethnic origin and religion into Catholic, Protestant, and Jewish contingents. Within these divisions there are numerous ethnic groups. The Irish hold aloof from the Italians, and the Italians move in different circles from the Poles. The Jews maintain a religious and social life separate from the gentiles. The *horizontal* strata that transect each of these vertical divisions are based upon the social values that are attached to occupation, education, place of residence in the community, and associations.

The vertically differentiating factors of race, religion and ethnic origin, when combined with the horizontally differentiating ones of occupation, education, place of residence and so on, produce a social structure that is highly compartmentalized. The integrating factors in this complex are twofold. First, each stratum of each vertical division is similar in its cultural characteristics to the corresponding stratum in the other divisions. Second, the cultural pattern for each stratum or class was set by the "Old Yankee" core group. This core group provided the master cultural mold that has shaped the status system of each sub-group in the community. In short, the social structure of the New Haven community is a parallel class structure within the limits of race, ethnic origin, and religion.

This fact enabled us to stratify the community, for our purposes, with an *Index of Social Position*.[11] This *Index* utilizes three scaled factors to determine an individual's class position within the community's stratificational system: ecological area of residence, occupation, and education. Ecological area of residence is measured by a six point scale; occupation and education are each measured by a seven point scale. To obtain a social class score on an individual we must therefore know his address, his occupation, and the number of years of school he has completed. Each of these factors is given a scale score, and the scale score is multiplied by a factor weight determined by a standard regression equation. The factor weights are as follows: Ecological area of residence, 5; occupation, 8; and education, 6. The three factor scores are summed, and the resultant score is taken as an index of this individual's position in the community's social class system.

This *Index* enabled us to delineate five main social class strata within the horizontal dimension of the social structure. These principal strata or classes may be characterized as follows:

Class I. This stratum is composed of wealthy families whose wealth is often inherited and whose heads are leaders in the community's business and professional pursuits. Its members live in those areas of the community generally regarded as "the best;" the adults are college graduates, usually from famous private institutions, and almost all gentile families are listed in the New Haven *Social Directory*, but few Jewish families are listed. In brief, these people occupy positions of high social prestige.

Class II. Adults in this stratum are almost all college graduates; the males occupy high managerial positions, many are engaged in the lesser ranking professions. These families are well-to-do, but there is no substantial inherited or acquired wealth. Its members live in the "better" residential areas; about one-half of these families belong to lesser ranking private clubs, but only 5 per cent of Class II families are listed in the New Haven *Social Directory*.

Class III. This stratum includes the vast majority of small proprietors, white-collar office and sales workers, and a considerable number of skilled manual workers. Adults are predominately high school graduates, but a considerable percentage have attended business schools and small colleges for a year or two. They live in "good" residential areas; less than 5

[11] A detailed statement of the procedures used to develop and validate this *Index* will be described in a forthcoming monograph on this research tentatively titled *Psychiatry and Social Class* by August B. Hollingshead and Fredrick C. Redlich.

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per cent belong to private clubs, but they are not included in the *Social Directory*. Their social life tends to be concentrated in the family, the church, and the lodge.

Class IV. This stratum consists predominately of semi-skilled factory workers. Its adult members have finished the elementary grades, but the older people have not completed high school. However, adults under thirty-five have generally graduated from high school. Its members comprise almost one-half of the community; and their residences are scattered over wide areas. Social life is centered in the family, the neighborhood, the labor union, and public places.

Class V. Occupationally, class V adults are overwhelmingly semi-skilled factory hands and unskilled laborers. Educationally most adults have not completed the elementary grades. The families are concentrated in the "tenement" and "cold-water flat" areas of New Haven. Only a small minority belong to organized community institutions. Their social life takes place in the family flat, on the street, or in neighborhood social agencies.

The second major technical operation in this research was the enumeration of psychiatric patients. A Psychiatric Census was taken to discover the number and kinds of psychiatric patients in the community. Enumeration was limited to residents of the community who were patients of a psychiatrist or a psychiatric clinic, or were in a psychiatric institution on December 1, 1950. To make reasonably certain that all patients were included in the enumeration, the research team gathered data from all public and private psychiatric institutions and clinics in Connecticut and nearby states, and all private practitioners in Connecticut and the metropolitan New York area. It received the cooperation of all clinics and institutions, and of all practitioners except a small number in New York City. It can be reasonably assumed that we have data comprising at least 98 per cent of all individuals who were receiving psychiatric care on December 1, 1950.

Forty-four pertinent items of information were gathered on each patient and placed on a schedule. The psychiatrists gathered material regarding symptomatology and diagnosis, onset of illness and duration, referral to the practitioner and the institution, and the nature and intensity of treatment. The sociologists obtained information on age, sex, occupation, education, religion, race and ethnicity, family history, marital experiences, and so on.

The third technical research operation was the selection of a control sample from the normal population of the community. The sociologists drew a 5 per cent random sample of households in the community from the 1951, New Haven *City Directory*. This directory covers the entire communal area. The names and addresses in it were compiled in October and November, 1950—a period very close to the date of the Psychiatric Census. Therefore there was comparability of residence and date of registry between the two population groups. Each household drawn in the sample was interviewed, and data on the age, sex, occupation, education, religion, and income of family members, as well as other items necessary for our purposes were placed on a schedule. This sample is our Control Population.

Our fourth basic operation was the stratification of the psychiatric patients and of the control population with the *Index of Social Position*. As soon as these tasks were completed, the schedules from the Psychiatric Census and the 5 per cent Control Sample were edited and coded, and their data were placed on Hollerith cards. The analysis of these data is in process.

SELECTED FINDINGS

Before we discuss our findings relative to Hypothesis I, we want to reemphasize that our study is concerned with *diagnosed* or *treated* prevalence rather than *true* or *total* prevalence. Our Psychiatric Census included only psychiatric cases under treatment, diagnostic study, or care. It did not include individuals with psychiatric disorders who were not being treated on December 1, 1950, by a psychiatrist. There are undoubtedly many individuals in the community with psychiatric problems who escaped our net. If we had *true* prevalence figures, many findings from our present study would be more meaningful, perhaps some of our interpreta-

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tions would be changed, but at present we must limit ourselves to the data we have.

Hypothesis I, as revised by the nature of the problem, stated: *The diagnosed prevalence of psychiatric disorders is related significantly to an individual's position* in the class structure. A test of this hypothesis involves a comparison of the normal population with the psychiatric population. If no significant difference between the distribution of the normal population and the psychiatric patient population by social class is found, Hypothesis I may be abandoned as unproved. However, if a significant difference is found between the two populations by class, Hypothesis I should be entertained until more conclusive data are assembled. Pertinent data for a limited test of Hypothesis I are presented in Table 1. The data included show the number of individuals in the normal population and the psychiatric population, by class level. What we are concerned with in this test is how these two populations are distributed by class.

TABLE I. DISTRIBUTION OF NORMAL AND PSYCHIATRIC POPULATION BY SOCIAL CLASS

Social Class	Normal Population*		Psychiatric Population	
	Number	Per cent	Number	Per cent
I	358	3.1	19	1.0
II	926	8.1	131	6.7
III	2500	22.0	260	13.2
IV	5256	46.0	758	38.6
V	2037	17.8	723	36.8
Unknown**	345	3.0	72	3.7
Total	11,422	100.0	1,963	100.0

Chi square=408.16, P less than .001.

* These figures are preliminary. They do not include Yale students, transients, institutionalized persons, and refusals.

** The unknown cases were not used in the calculation of chi square. They are individuals drawn in the sample, and psychiatric cases whose class level could not be determined because of paucity of data.

When we tested the reliability of these population distributions by the use of the chi square method, we found a *very significant* relation between social class and treated prevalence of psychiatric disorders in the New Haven community. A comparison of the percentage distribution of each population by class readily indicates the direction of the class concentration of psychiatric cases. For example, Class I contains 3.1 per cent of the community's population but only 1.0 per cent of the psychiatric cases. Class V, on the other hand, includes 17.8 per cent of the community's population, but contributed 36.8 per cent of the psychiatric patients. On the basis of our data Hypothesis I clearly should be accepted as tenable.

Hypothesis II postulated a significant connection between the *type* of psychiatric disorder and social class. This hypothesis involves a test of the idea that there may be a functional relationship between an individual's position in the class system and the type of psychiatric disorder that he may present. This hypothesis depends, in part, on the question of diagnosis. Our psychiatrists based their diagnoses on the classificatory system developed by the Veterans Administration.[12] For the purposes of this paper, all cases are grouped into two categories: the neuroses and the psychoses. The results of this grouping by social class are given in Table 2.

TABLE II. DISTRIBUTION OF NEUROSES AND PSYCHOSES BY SOCIAL CLASS

Social Class	Neuroses		Psychoses	
	Number	Per cent	Number	Per cent
I	10	52.6	9	47.4
II	88	67.2	43	32.8
III	115	44.2	145	55.8
IV	175	23.1	583	76.9
V	61	8.4	662	91.6
Total	449		1,442	

Chi square=296.45, P less than .001.

A study of Table 2 will show that the neuroses are concentrated at the higher levels and the psychoses at the lower end of the class structure. Our team advanced a number of theories to explain the sharp differences between the neuroses and psychoses by social class. One suggestion was that the low percentage of neurotics in the lower classes was a direct reaction to the cost of psychiatric treatment. But as we

[12] *Psychiatric Disorders and Reactions,* Washington: Veterans Administration, Technical Bulletin 10A-78, October, 1947.

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accumulated a series of case studies, for tests of Hypotheses IV and V, we became skeptical of this simple interpretation. Our detailed case records indicate that the social distance between psychiatrist and patient may be more potent than economic considerations in determining the character of psychiatric intervention. This question therefore requires further research.

The high concentration of psychotics in the lower strata is probably the product of a very unequal distribution of psychotics in the total population. To test this idea, Hollingshead selected schizophrenics for special study. Because of the severity of this disease it is probable that very few schizophrenics fail to receive some kind of psychiatric care.

tionately prevalent in a social class the index is above 100; if schizophrenia is disproportionately low in a social class the index is below 100. The index for each social class appears in the last column of Table 3.

The fact that the Index of Prevalence in class I is only one-fifth as great as it would be if schizophrenia were proportionately distributed in this class, and that it is two and one-half times as high in class V as we might expect on the basis of proportional distribution, gives further support to Hypothesis II. The fact that the Index of Prevalence is 11.2 times as great in class V as in class I is particularly impressive.

Hypothesis III stipulated that the type of psychiatric treatment a patient receives is

TABLE III. COMPARISON OF THE DISTRIBUTION OF THE NORMAL POPULATION WITH SCHIZOPHRENICS BY CLASS, WITH INDEX OF PROBABLE PREVALENCE

Social Class	Normal Population		Schizophrenics		Index of Prevalence
	No.	Per cent	No.	Per cent	
I	358	3.2	6	.7	22
II	926	8.4	23	2.7	33
III	2,500	22.6	83	9.8	43
IV	5,256	47.4	352	41.6	88
V	2,037	18.4	383	45.2	246
Total	11,077	100.0	847	100.0	

This diagnostic group comprises 44.2 per cent of all patients, and 58.7 per cent of the psychotics, in our study. Ninety-seven and six-tenths per cent of these schizophrenic patients had been hospitalized at one time or another, and 94 per cent were hospitalized at the time of our census. When we classify these patients by social class we find that there is a very significant inverse relationship between social class and schizophrenia.

Hollingshead decided to determine, on the basis of these data, what the probability of the prevalence of schizophrenia by social class might be in the general population. To do this he used a proportional index to learn whether or not there were differentials in the distribution of the general population, as represented in our control sample, and the distribution of schizophrenics by social class. If a social class exhibits the same proportion of schizophrenia as it comprises of the general population, the index for that class is 100. If schizophrenia is disproportionately

associated with his position in the class structure. A test of this hypothesis involves a comparison of the different types of therapy being used by psychiatrists on patients in the different social classes. We encountered many forms of therapy but they may be grouped under three main types; psychotherapy, organic therapy, and custodial care. The patient population, from the viewpoint of the principal type of therapy received, was divided roughly into three categories: 32.0 per cent received some type of psychotherapy; 31.7 per cent received organic treatments of one kind or another; and 36.3 per cent received custodial care without treatment. The percentage of persons who received no treatment care was greatest in the lower classes. The same finding applies to organic treatment. Psychotherapy, on the other hand, was concentrated in the higher classes. Within the psychotherapy category there were sharp differences between the types of psychotherapy administered to the several classes.

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For example, psychoanalysis was limited to classes I and II. Patients in class V who received any psychotherapy were treated by group methods in the state hospitals. The number and percentage of patients who received each type of therapy is given in Table 4. The data clearly support Hypothesis III.

At the moment we do not have data available for a test of Hypotheses IV and V. These will be put to a test as soon as we complete work on a series of cases now under close study. Preliminary materials give us the impression that they too will be confirmed.

TABLE IV. DISTRIBUTION OF THE PRINCIPAL TYPES OF THERAPY BY SOCIAL CLASS

	Psychotherapy		Organic Therapy		No Treatment	
Social Class	Number	Per cent	Number	Per cent	Number	Per cent
I	14	73.7	2	10.5	3	15.8
II	107	81.7	15	11.4	9	6.9
III	136	52.7	74	28.7	48	18.6
IV	237	31.1	288	37.1	242	31.8
V	115	16.1	234	32.7	367	51.2

Chi square=336.58, P less than .001.

CONCLUSIONS AND INTERPRETATIONS

This study was designed to throw new light upon the question of how mental illness is related to social environment. It approached this problem from the perspective of social class to determine if an individual's position in the social system was associated significantly with the development of psychiatric disorders. It proceeded on the theoretical assumption that if mental illnesses were distributed randomly in the population, the hypotheses designed to test the idea that psychiatric disorders are connected in some functional way to the class system would not be found to be statistically significant.

The data we have assembled demonstrate conclusively that mental illness, as measured by diagnosed prevalence, is not distributed randomly in the population of the New Haven community. On the contrary, psychiatric difficulties of so serious a nature that they reach the attention of a psychiatrist are unequally distributed among the five social classes. In addition, types of psychiatric disorders, and the ways patients are treated, are strongly associated with social class position.

The statistical tests of our hypotheses indicate that there are definite connections between particular types of social environments in which people live, as measured by the social class concept, and the emergence of particular kinds of psychiatric disorders, as measured by psychiatric diagnosis. They do not tell us what these connections are, nor how they are functionally related to a particular type of mental illness in a given individual. The next step, we believe, is to turn from the strictly statistical approach to an intensive study of the social environments associated with particular social classes, on the one hand, and of individuals in these environments who do or do not develop mental illnesses, on the other hand. Currently the research team is engaged in this next step but is not yet ready to make a formal report of its findings.

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